December 20, 2018

POLARIS PULSE

An Informational Bulletin Brought To You By Polaris Group

CMS Strengthens Nursing Home Oversight to Ensure Adequate Staffing

The Centers for Medicare & Medicaid Services (CMS) published a memo on November 30, 2018 to announce actions that will bolster nursing home oversight and improve transparency in order to ensure that facilities are staffed adequately.

CMS will utilize Payroll-Based Journal (PBJ) data to identify providers that have a significant drop in staffing levels on weekends or have several days in a quarter without a registered nurse (RN) working. The names of these providers will be shared with state survey agencies so that some weekend surveys can be conducted. If the surveys find insufficient nursing levels, facilities will be cited for non-compliance.

CMS has published a new update to the PBJ Policy Manual and FAQs. Key updates include a more thorough explanation of the Meal Break Policy, reiterating that 30 minutes for every 8 hours worked need to be deducted for a meal break for every shift that exempt, non-exempt, or contract employees work regardless of whether the break is paid. If staff takes a meal break that is longer than 30 minutes, the actual time of the break should be excluded. The updates also include instructions for reporting hours for "universal care workers." CMS has added language to both the PBJ Policy Manual and the PBJ Policy FAQ to instruct facilities that they must use a reasonable methodology to allocate the hours that these employees are providing CNA services and report these hours accordingly. Hours spent on other duties (i.e. housekeeping, cooking etc.) must not be reported as CNA hours

In addition, CMS has created two reports for providers to help ensure data is submitted accurately and in a timely manner. These reports use the same methodology CMS uses to calculate each facility's census, which is then used to calculate the number of staff hours per resident per day posted on the Nursing Home Compare website.
These reports are:

The MDS Census Summary Report: Allows users to retrieve the daily MDS-based resident census (i.e., count of residents) for each day in a quarter.

MDS Census Detail Report: Allows users to retrieve a list of the residents that the MDS-based census is comprised of on a given date or dates.

For the updated PBJ Policy Manual and FAQ: http://polaris-group.com/news_releases.asp

CMS Informs State of Case-Mix Payment Changes

The Centers for Medicare & Medicaid Services (CMS) has issued a Center for Medicaid & CHIP Services (*CMCS) Informational Bulletin* informing states of changes that could impact states' payments for Medicaid beneficiaries in nursing facilities.

Effective October 1, 2019, CMS will replace the existing Resource Utilization Group (RUG), Version 4 case-mix methodology that is used to classify Skilled Nursing Facility (SNF) patients in a covered Part A stay for payment purposes under the SNF Prospective Payment System with a new case-mix classification model, the Patient Driven Payment Model (PDPM).

On October 1, 2020, CMS will no longer support RUG-III and RUG-IV case-mix methodologies via the Minimum Data Set (MDS). PDPM utilizes a streamlined assessment schedule compared to RUG-III and RUG-IV by eliminating all current scheduled assessments, except the 5-day, and all unscheduled assessments (i.e., Other Medicare-Required Assessments). For States that rely on these assessments for calculating their case-mix group, CMS has created an optional assessment so that Medicaid payment is not adversely impacted when PDPM is implemented on October 1, 2019. States will have some flexibility in creating policies associated with this assessment. The optional assessment will be effective from October 1, 2019 through September 30, 2020.

CMS will be removing several MDS data elements over the next few years. Many MDS data elements used in RUG-III and RUG-IV are no longer required for Federal purposes. With the removal of data elements, RUG-III and RUG-IV will no longer be functional. States that continue to use RUG-III or RUG-IV after October 1, 2020 will need to implement a new process to gather the needed data.

To read the complete CMCS Informational Bulletin: http://polaris-group.com/news_releases.asp

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SNF VBP Program Release Public Reporting Files

The Centers for Medicare and Medicaid Services (CMS) recently released the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program year public reporting files for **Calendar Year 2017** performance. The files contain scoring and measure performance for the SNF 30-Day All-Cause Readmission Measure as well as associated payment incentives for all SNFs. This information is available on the Nursing Home Compare website.

Until now, SNFs have only been able to review their individual scores, but with the release of this data, SNFs now have their first chance to measure themselves compared to how others in the sector are performing. Some of the results include the following: from the 15,000 facilities taking part, 10,976 nursing homes (73%) are being penalized under the SNF VBP Program, while only 3,983 nursing homes (27%) are receiving bonuses. Incentives were based on both how SNF's hospitalization rates in 2017 performance year compared to other facilities, and how much rates changed since 2015. With the incentives, Medicare is redistributing $316 million from poor-performing SNFs to facilities that excelled, and Medicare will keep $211 million.

Transition to New Medicare Cards

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based Health Insurance Claim Number (HICN). The new MBI is noticeably different from the HICN. Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions. The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between "0" and "O").

CMS began mailing new cards in April 2018 and will meet the statutory deadline for replacing all Medicare cards by April 2019.

There are three ways you and your office staff can get MBIs:

1. Ask your Medicare patients
Ask your Medicare patients for their new Medicare card when they come for care.

2. Use the MAC's secure MBI look-up tool
You can look up MBIs for your Medicare patients when they don't or can't give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end on December 31, 2019. For a provider portal list: http://polaris-group.com/news_releases.asp

3. Check the remittance advice
Starting in October 2018 through the end of the transition period, CMS will return the MBI on every remittance advice when you submit claims with valid and active Health Insurance Claim Numbers (HICNs).

You can start using the MBIs even if the other health care providers and hospitals who treat your residents have not. When the transition period ends on December 31, 2019, you must use the MBI for most transactions

Use the MBI the same way you use the HICN today. Put the MBI in the same field where you have always put the HICN. This also applies to reporting informational only and no-pay claims. **Do not use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you have always put the HICN. After that, the remittance advice will tell you if we rejected claims because the MBI wasn't used. It will include Claim Adjustment Reason Code (CARC) 16, "Claim/service lacks information or has submission/billing error(s)." along with Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier".

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions.

For the CMS MLN fact sheet: http://polaris-group.com/news_releases.asp

December OIG Updates

States' Compliance with FFS and MCO Provider Enrollment Requirements

Provider enrollment is a key program integrity tool to protect Medicaid from fraudulent and abusive providers. The 21st Century Cures Act (the Cures Act) requires States to enroll all Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs). This study, mandated by the Cures Act, will survey State Medicaid agencies about their enrollment of FFS and managed care providers and implementation of required provider enrollment screening activities.

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Polaris Group Solution Center Hotline Q&A "Where No Question Goes Unanswered!"

Question
We had a resident who came in with a right hip fracture/ surgical site. When does the fracture diagnosis come off Section "I"?

Answer:
It comes off Section I when it is no longer an active diagnosis according to the RAI definition. Here is what determines if it is active:

ACTIVE DIAGNOSES: Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Question:
When resident exhausts their 100 days of Medicare benefits and switch to a supplementary insurance or become private pay do I need to complete a Medicare A assessment? According to our billing department, it is not needed.

Answer:
Yes, you need to complete the SNF End of PPS Stay discharge aka the NPE MDS.

Question:
We have a resident who fell and sustained a fracture so we did a significant change in status in October. Now the resident might be admitted to hospice. Does that mean we need to do another significant change in status once she elects hospice?

Answer:
Yes.

2019 WEBINAR TRAININGS
Polaris Group is pleased to offer the following
CEU approved live Webinars

	Date
Triple Check Training Triple Check and More!	1/8
ICD-10 IMPACT on PDPM Training **Hot New Topic* ICD-10-CM IMPACT on PDPM	1/9
PDPM Introduction Training **Hot New Topic* Introduction to Patient Driven Payment Model	1/15

Please join us!
For further information, please contact the Webinar Department at: 800-275-6252 ext. 250
or register online at: www.polaris-group.com

2019 LTC Dates

POLARIS GROUP LTC TRAINING INSTITUTE

Comprehensive 3-day training workshops to implement a compliant and successful Medicare program

SNF Billing Basics
February 19-21 Orlando, FL
April 16-18 St. Louis, MO

Medicare & PPS/PDPM & SNFQRP Compliance
February 26-28 Las Vegas, NV

Advanced Billing
March 19-21 Las Vegas, NV
May 21-23 Dallas, TX

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